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BULLETIN of the
MENNINGER CLINIC

VOLUME 9 NOVEMBER, 1945 NUMBER 6

Smith Ely Jelliffe
1866–1945

Peter Bassoe
1874–1945

I should like to write a very personal memorial notice concerning two great men in our field of medicine, both of whom contributed much to it and both of whom greatly influenced my life and therefore had a direct connection with the institutions and organizations with which I am connected.

My teacher, Ernest Southard, died in 1919. His brilliant and catholic mind was none the less capable of stubborn prejudices and one of these prejudices was against psychoanalysis. Yet it was through him that I had met Smith Ely Jelliffe of New York, one of the most vigorous and most gifted of the protagonists of psychoanalysis at that time. Doctor Jelliffe was like Doctor Southard in his catholicity of mind and in his brilliance; he was less philosophical than Southard but more erudite and far more experienced clinically. I remember with deep gratitude how he took me under his wing after Southard died—me, a youngster fresh out of my hospital training, unknown to anyone in the field. Doctor Jelliffe introduced me to people, to experiences, and, above all, to ideas. He took me into his home where I was impressed no less by the thousands of volumes of neurologic and psychiatric wisdom than by the infinite variety of home-made wines and liqueurs and the enormous collections of fungi, mosses and pressed botanical specimens.

It was Jelliffe who introduced me to clinical psychoanalysis; prior to that time I had known only the published material of Freud, Jones, Brill, Frink and others. In those days a personal analysis was not regarded as a necessary prerequisite to the clinical practice of psychoanalysis and it was Jelliffe who first encouraged me to try the experiment of listening for a time to free associations and judging for myself whether or not they had any clinical meaning. I recall a private meeting of a few psychoanalysts in New York to which Doctor Jelliffe took me at which one of the members of the group described in considerable detail his own personal experiences in analysis with Professor Freud, subsequently discussed by all those present as if it were an ordinary clinical case.

In those early days of psychoanalysis Jelliffe always stood for an open-minded consideration of the theories and findings of all workers. He was regarded by some as being Adlerian and by others as being Jungian. I

think he did give considerable weight to the ideas of these men, particularly Jung, but basically he was Freudian in the best sense of that word. As he grew older he became more and more definitely so. In fact I recall very clearly his angry reaction to an article of Jung's which we read together; what he objected to were certain claims of Jung for priority which he said actually belonged to Freud.

Doctor Jelliffe saw no borderlines between medicine, neurology, psychiatry and psychoanalysis. This seems obvious enough today but in 1920 this was more than heresy; it was either "dilettantism" or "psychosis". I have heard Jelliffe described by envious and hostile critics as belonging in both categories. Nothing could be more inaccurate. The profundity and orderliness of Jelliffe's investigations were evident in whatever field or aspect he wrote about. He was an exceptionally fine neurologist and an exceptionally fine psychiatrist and an exceptionally fine internist. He knew all these fields just as he knew the fields of mycology, botany, geography, chemistry and many others. He knew the essential contribution of every European worker in neurology and psychiatry, and knew most of the leaders personally. His reading was prodigious and his memory equal to his voracious reading.

It is apt to be forgotten in these days of "psychosomatic medicine" that Jelliffe was writing about the emotional factors in physical disease thirty years ago. When he suggested (1916) that psoriasis might be a "hysterical conversion syndrome," or that tuberculosis was in some degree amenable to psychotherapy (1919) or that psychogenic factors were present in multiple sclerosis (1921), bone disease (1923), hypertension, urinary system disorders and many other "somatic" conditions (1925-1935), he was laughed at; he was maligned; he was ignored. But he was also respected, listened to and imitated. Psychiatrists began to think about the possibility that their field extended beyond the description of delusions and hallucinations. He and his longtime associate, William Alanson White, and their mutual friend, A. A. Brill, were the real fathers of psychoanalysis in this country; and Jelliffe should be regarded as the founder of psychosomatic medicine and credited with the introduction of the term.

Doctor Jelliffe died on September 25, 1945, after a long illness against which he battled with great courage. His funeral was held in his home at Hulett's Landing on Lake George, and he was buried near there in the forest, among the trees he had seen grow from sprouts. In this quiet spot (his wife writes) "the winds alone will move the trees to sound, and summer rain will fall and winter snow; the small animals he loved will scamper over him. His frantic seeking for knowledge, his bright spirit will rest. Surely he will now know all that he sought."

* * *

Only a few weeks after this one great tree had fallen, the thin forest of our medical leaders was depleted by the fall of another giant.

Peter Bassoe, who died in Chicago on November 5, 1945, was a man very different in type from Smith Ely Jelliffe but similar in being a great leader, teacher and friend. Doctor Bassoe was a neurologist, pure and simple. He never laid claim to any considerable knowledge of psychiatry although he was always interested in it and never displayed the depreciatory attitude toward it which used to prevail in some neurological centers. For many years he edited the *Yearbook of Neurology and Psychiatry* with eminent fairness to the latter field. Thousands of medical students learned clinical neurology under his tutelage. He contributed many original articles of significant scientific value. But in my own opinion, his greatest contribution was the inspiration given to his many colleagues by the strength and beauty of his personal character.

My personal association with Doctor Bassoe began shortly after I had met Doctor Jelliffe. In the winter of 1921 I called upon him in Chicago and was most hospitably received. He showed me his work in the Rush Medical College and the Presbyterian Hospital, with which he was long associated, and took me to his home in Evanston where I became well acquainted with his wife, herself a physician, their son and their four daughters. Doctor Bassoe and I talked about the formation of an organization of neurologists and psychiatrists practicing in the middle west. He endorsed the idea heartily and suggested a list of men who might form the nucleus of such a body. At our first informal meeting in St. Louis in 1922 he presided and was unanimously chosen temporary chairman and later elected our first president.

The Central Neuropsychiatric Association thus born grew to be a sizable body; I have often heard it described as the liveliest neuropsychiatric organization in the world. Whatever success it has achieved is certainly to be ascribed in large part to Peter Bassoe, who has been present at every meeting since its formation, served on almost every committee, counseled every president and secretary. All of us will remember him as a kindly, wise, gentle, fatherly man who was fair to everyone, considerate of everyone, friendly to everyone, a man who never did a mean or selfish thing in his life, who never expressed an ungenerous or bitter sentiment. He was able to do this without swerving for a moment from his scientific ideals and his professional work.

This is what we shall remember.

KARL MENNINGER, M.D.

November 8, 1945

THE MOTIVES OF DEFENSE*

By OTTO FENICHEL, M.D.

The psychoneuroses are based on the neurotic conflict. The conflict results in the blocking of necessary discharges and in this way creates a state of being dammed up. This state gradually gives rise to a relative insufficiency of the ego's capacity to master excitation. The precipitating factors of psychoneuroses must be looked upon as relative traumata; stimuli which, were it not for the state of being dammed up, would have been mastered without difficulty, now create a relative insufficiency.

The neurotic conflict, by definition, is one between a tendency striving for discharge and another tendency that tries to prevent this discharge. The intensity of the tendency toward discharge, it has been stated, depends not only upon the nature of the stimulus but, even more, upon the physicochemical state of the organism. In general it is permissible to equate the tendencies that strive for discharge with drives ("instinctual impulses"); the sieving of drives, that is, the decision as to whether or not their discharge should be permitted, has been defined as a function of the ego. Therefore, the general formulation would be: *the neurotic conflict takes place between drives, that is, the id and the ego.*[12,13]

Are Neurotic Conflicts between Opposing Instincts Possible?

Is this formula valid for all neurotic conflicts? Or would it be conceivable for a neurotic conflict to take place between two instinctual demands with contradictory aims? Certain clinical facts seem to prove, for example, that homosexuality may repress heterosexual impulses or that sadism may repress masochism.[1, 11]

However, if the history of conflicts of this type is investigated it is regularly found that the apparent conflict between instincts merely covers or represents another conflict between an undesirable instinct and some fear or guilt feeling that objects. This objecting force succeeded in increasing the intensity of some other drive—the aim of which was opposed to that of the original objectionable drive—because this increase helped strengthen the intended defense. An instinctual conflict at the basis of a neurosis is always a structural conflict as well; one of the conflicting instincts represents the ego, that is, is sustained by an ego defense, or

* Dr. Fenichel read this paper, Chapter VIII in his recent book, *The Psychoanalytic Theory of Neurosis* (New York, W. W. Norton & Co., Nov. 1945), before the Topeka Psychoanalytic Society, May 18, 1945, in Topeka.

strengthened for purposes of ego defense. Although itself an instinct, it acts as a defense against a more deeply repressed instinct. The concepts of "instinct" and "defense" are relative; the two are always interpenetrated; reaction formations especially make use of reinforcements of instincts with opposite aims. Instincts contradictory in aim, without such reinforcement by the defending ego, would not conflict with each other. Within the realm of the id there is no conception of contradiction; logical order is here nonexistent. Instincts contradictory in aim can be satisfied one after the other, sometimes even simultaneously, by one and the same derivative. Freud raised the question as to why certain persons experience contradictory instincts as conflicting and are troubled about them, whereas others do not feel them as conflicting at all.[19] The answer is that this depends upon whether or not the contradiction between the instinctual aims involves a structural conflict as well.[4, 5]

In the last analysis, anxiety and guilt feelings motivating structural conflicts also express instinctual demands, namely, demands of a self-preserving instinct, or of an instinct to preserve mother's love.

To summarize: The fact that there are conflicts between instincts does not necessitate any change in the formula: the neurotic conflict takes place between the id and the ego.

The External World in Neurotic Conflicts

The motives of defense are rooted in external influences. However, the external world as such cannot repress. It can only compel the ego to develop repressing forces. Without an intrapsychic institution that represents and anticipates the external world, no defense and no neurosis could arise. An original conflict between the id and the external world must first have been transformed into a conflict between the id and the ego before a neurotic conflict can develop.

The external world cannot ward off impulses except through the ego. However, external perceptions perhaps may be warded off, and in this way participate in a neurotic conflict. In the discussion of traumatic neuroses, fainting and the blocking of further perceptions demonstrated that the external world (the perceptions) may be warded off. A similar phenomenon occurs in psychoneuroses: there are negative hallucinations, representing a warding off of some part of the external world; there is forgetting or the misinterpreting of outer events to achieve wish fulfillment; there are all kinds of mistakes in reality testing under the pressure of derivatives of unconscious wishes or fears. Whenever a stimulus gives rise to painful feelings, a tendency is developed not only to ward off these feelings but also to ward off the stimulus.

However, none of these neurotic falsifications of reality can be distinguished exactly from repressions that are directed against one's own impulses. The external world is warded off as a possible source of punishment or as a possible source of temptation to unconscious objectionable drives. Situations are avoided or forgotten because they represent an inner instinctual demand. Here, again, the conflict between the ego and the external world reflects a conflict between the ego and the id.

Sometimes a part of the external world is warded off not to avoid the mobilization of an instinct but to deny the idea that the instinctual act may be dangerous or cause pain; that is, the prohibitive character of the external world may be warded off. In general, this type of denial cannot be carried far in neuroses because the reality-testing function of the ego prevents a too obvious falsification.[8]

Freud once expressed the opinion that herein may lie the basic difference between neurosis and psychosis. Both disturbances are based on a conflict between an instinctual impulse and a fear of the possible pain connected with it: the neurotic individual represses the instinct and thus obeys the threatening external world; the psychotic individual denies the external world and obeys his urgent instinct.[13] This contrast, however, is only relatively valid.[14] First of all, wish-fulfilling falsifications also occur in every neurosis. Freud studied them especially in fetishism;[17] and he showed later that frequently persons who consciously know some fact very well indeed behave as if they had not noticed it or did not believe it. The ego of such persons is actually split into a conscious part that knows reality and an unconscious part that denies reality. Often such a split manifests itself in slips and errors.[20, 21] Second, there is no doubt that psychotics who falsify reality do not always do so in terms of a simple wish fulfillment; very often they do so to escape an instinctual temptation, or to defend themselves against their instincts, exactly as neurotics do, only applying other mechanisms and deeper regressions.[22]

To summarize: There are defensive attitudes against painful perceptions just as there are defenses against any pain. Nevertheless, in psychoneuroses based on the blocking of discharge, the defenses against instinctual impulses remain in the foreground; defenses against perceptions (and affects) seem to be performed first and foremost in the service of defenses against instincts. Again: the neurotic conflict takes place between the ego and the id.

The Superego in Neurotic Conflicts

The superego, of course, brings some complication into the picture. The conflict *ego vs. id* would in some neuroses more correctly be written *ego + superego vs. id*, and in others *ego vs. id + superego*.

After the superego has been established, it is responsible to a great extent for the decision as to which discharges are permitted and which are negated. The warding-off ego acts under the command of the superego, and wherever it is not simple anxiety but guilt feelings that motivate the defense, the formulation *ego + superego vs. id* is correct.

On the other hand, in many neuroses (especially in compulsion neuroses and, to an extreme degree, in depressions) the ego defends itself against guilt feelings. All the defense mechanisms usually employed in the fight against instincts may also become directed against the "anti-instincts" originating in the superego. In such cases, the ego develops a double countercathexis, one against the instincts and another one against the superego. And the warded-off guilt feelings may in turn break through against these defenses in a distorted form, in the same way as instincts do: *ego vs. id + superego.*

Again we may summarize: The superego may participate on either side in the neurotic conflict, but the formulation remains valid: the neurotic conflict takes place between the ego and the id.

Anxiety as Motive for Defense

Let us recapitulate what already has been stated about the motivations of neurotic conflicts. The infant, unable to attain satisfaction by his own efforts, necessarily often gets into traumatic situations, from which the first idea arises that instincts may be dangerous. Then more specific experiences show that instinctual acts may actually be dangerous; this impression may be warranted, or may be based on an animistic misinterpretation. The ego turns against instincts because it believes—correctly or incorrectly—them to be dangerous. Thus the problem of anxiety is the essence of any psychology of neurotic conflicts.[15]

The primary anxiety, or the first experiences out of which later anxiety develops, is a manifestation of unmastered tension. It is an automatic occurrence that takes place whenever the organism is flooded with excitement; the symptoms of the traumatic neurosis show that it is not limited to infancy. This primary or traumatic anxiety occurs automatically, makes its appearance as panic, and is experienced by the ego passively; it can be understood partly as the way in which the unmastered tension makes itself felt and partly as an expression of vegetative emergency discharges.

Later on, the ego learns to use previously automatic archaic reactions for its purposes. The ego's judgment of impending danger brings the organism into a state similar to that of a trauma, but of lower intensity. The "tamed" anxiety, thus developed by the ego in the case of danger, may be called an anxiety signal, for it is used to indicate the necessity for starting defensive action.[16] That component of anxiety appropriate to danger

situations, preparation for defense, arises from the fact that it is the ego that uses anxiety; what is inappropriate, the fact that anxiety sometimes blocks the pertinent attitude, is due to the circumstance that the ego has no other material at hand than an archaic automatic mechanism.

Thus in the last analysis, all anxiety is a fear of experiencing a traumatic state, of the possibility that the organization of the ego may be overwhelmed by excitation. However, after the ego is developed enough to control instinctual actions and to bring about gratifications, the instinctual impulses ought not to be frightening anymore. If they still are, it is due to the fact that fears over loss of love or of castration have induced the ego to block the normal course of its excitements, thus creating an insufficiency of discharge.[3]

Sometimes, as has been stated, the ego's capacity to tame anxiety fails. The judgment that was intended to avert a traumatic state may actually induce it. This happens in the anxiety spells of anxiety hysterias, but it also happens in normal persons when they react to danger with paralyzing panic. The ego's intention to give an anxiety signal fails when the person in whom the failure occurs is, as a result of previous repressions, in a dammed-up state; the slight anxiety added by the judgment of danger acts like a lighted match in a powder keg.

Among a group of persons subjected to the same real danger, those are more likely to react with panic who have no opportunity to master their tension in any other way. Such opportunity may be blocked by external circumstances; it is easier to master anxiety while some task is to be fulfilled or some motions can be made than if one is forced to wait quietly. Or the opportunity may be blocked by internal circumstances, by a state of "readiness for anxiety," due either to antecedent strain or to previous repressions. This also holds true for children, whose reaction, beside, is also dependent on that of the grownups around them.[4]

This triple stratification of anxiety may be summarized in a short table:

Anxiety

(1) Trauma	Anxiety automatic and unspecific
(2) Danger	Anxiety in the service of the ego, affect created by anticipation, controlled and used as a warning signal
(3) Panic	Ego control fails, affect becomes overwhelming, regression to state (1); anxiety spell in anxiety hysteria

The same triple stratification will be found again in all other affects.

Should the anxiety signal be designated as a countercathexis? This seems warranted because it is initiated by the ego and based on an active anticipation of some future possibility. On the other hand it is the expression of an automatic occurrence in the depth of the organism as a consequence of the ego's reaction; it is not created by the ego; it is, rather, used by it. In this sense, the anxiety signal is a typical example of the

dialectic nature of countercathexis in general. The forces the ego uses against the instincts are derivatives of the instincts themselves.

Guilt Feelings as Motive for Defense

The neurotic conflict becomes more complicated when anxiety is replaced by guilt feelings. Guilt feelings represent a topically defined anxiety, the anxiety of the ego toward the superego.

Guilt feeling proper—that is, the feeling "I have done wrong," a painful judgment about some past occurrence which has the character of remorse—must be distinguished from feelings of conscience which do not judge the past but the future: "I should do this," or "I should not do that." This part of conscience has a *warning* function and directs future actions of the personality.

Having designated the ego's judgment "Do not do that, otherwise something terrible may happen" as the root of "danger anxiety," we now may assume that the warning conscience feeling is a special case of the same ego function: "Do not do this, otherwise some specific terrible thing may happen."

What is this specific thing? What does "punishment by the superego" or "loss of the superego's love" actually mean? Obviously, that type of pain is feared which is actually felt, to a greater or less degree, in guilt feeling proper. The warning function of conscience expresses the ego's tendency to avoid the pains of intense guilt feelings. These pains constitute a specific displeasure, the avoidance of which is the aim of the conscientious person. As long as a real punishment is feared, or hell is thought of as a threatening reality, there is no true conscience yet, for the tendency to avoid punishment and hell does not differ from tendencies developed by other anxiety signals. In "conscience" the fear is internalized, and the danger threatens *from within*. Fear is felt not only lest something terrible occur within the personality but also lest there be a loss of certain pleasurable feelings, such as well-being, protection, and security, which were hitherto present. This feared loss may be characterized as a loss of self-esteem, the most extreme degree of which is a feeling of annihilation.

To summarize, the warning conscience says: "Avoid this or that action, otherwise you will experience a feeling of annihilation." Guilt feeling proper is more or less a materialization of this threat, which in turn may be used to avoid future similar actions, which might even intensify the feeling of annihilation.

This feeling of annihilation must be characterized as a cessation of the narcissistic supplies which were initially derived from the affection of some external person and later from the superego.

The consideration that what the normal conscience tries to avoid has actually happened in melancholia makes the melancholic feeling of annihilation comparable with the paralyzing panic in the third type of anxiety. The table of triple stratification given for anxiety may also be applied to the problems of guilt feeling. Conscience and warning guilt feelings correspond to the second state (to the warning "danger anxiety"), the melancholic feeling of annihilation to the third state, panic. But what corresponds to the first state of "trauma"?

In anxiety, the first state was the unspecific painful experience which the infant had to undergo in a traumatic state. In the case of guilt feeling the situation must be similar, but more specific. The assumption that here the feeling of a "danger from within" is not so much based on a general "traumatic tension" but on specific feelings of hunger can be supported by many clinical experiences about the connection between guilt feelings and oral strivings, to be discussed more fully later. Thus a new triple stratification may be formulated for guilt feeling:

Guilt Feeling

(1) Trauma	Feeling of hunger or annihilation automatic
(2) Danger	"Annihilation" in the service of the ego, affect created by anticipation, controlled and used as a warning signal
(3) Panic	Ego control fails, affect becomes overwhelming, regression to state (1); "annihilation" spell in melancholia

Now an important complication must be added: the primary actual hunger is for milk. Later on, narcissistic supplies are missed in the same way in a kind of mental hunger. When the ego is sufficiently developed to form a judgment that there is danger of a cessation of essential narcissistic supplies, the aim of its signal, "annihilation may occur," must be to influence objects to furnish these supplies. This state represents the anxiety over loss of love which plays so important a role as a motive for defense.

In persons whose self-esteem is regulated by the anxiety over loss of love, secondary anxieties and guilt feelings may be aroused if they try to enforce the necessary supplies by objectionable means. Particularly unfortunate are persons who need narcissistic supplies but who at the same time unconsciously are afraid of receiving them.

The anxiety over loss of love, or rather the anxiety arising out of loss of narcissistic supplies, turns into anxiety over loss of the superego's supplies, and the fear into guilt feeling. Thus the second stage of the table about guilt feeling must be divided into two substages: in the first, the loss of narcissistic supplies threatens from without, in the second from within. Now the parallelism between anxiety and guilt feelings may be completed with the following table:

Anxiety

(1) Trauma	Anxiety automatic and unspecific
(2) Danger	Anxiety in the service of the ego, affect created by anticipation, controlled and used as a warning signal
(3) Panic	Ego control fails, affect becomes overwhelming, regression to state (1); anxiety spell in anxiety hysteria

Guilt Feeling (a Specific Anxiety)

(1) Trauma	Feeling of annihilation automatic, caused by: (a) lack of food (b) lack of affection (of narcissistic supplies)
(2) Danger	"Annihilation" in the service of the ego, affect created by anticipation, controlled and used as a warning signal (a) Before establishment of the super-ego: anxiety over loss of love (over loss of narcissistic supplies) (b) After establishment of the super-ego; conscience (regulating inner narcissistic supplies)
(3) Panic	Ego control fails, affect becomes overwhelming; regression to state (1); "annihilation" spell in melancholia

The change from state (2*a*) to (2*b*) is initiated when the anticipating ego begins to guard against any action on its part that might result in a loss of the necessary parental love; the change is completed with the resolution of the Oedipus complex by the introjection of its objects. The state (2*b*) is an essential characteristic of mental normality. Everyone continually experiences slight "conscience signals" which regulate behavior and which are of far greater importance as constituents of the so-called mood than general anxiety signals are.

"Conscience" becomes pathological when it (*a*) functions in too rigid or too automatic a manner, so that realistic judgment about the actual outcome of intended actions is disturbed ("archaic superego") or (*b*) when the breakdown toward "panic" occurs and a greater or lesser sense of complete annihilation is experienced instead of a warning signal, which is the case in severe depressions. The causes of such failure of conscience will be investigated later. Here a few remarks are pertinent on certain features that are characteristic of guilt feelings in general.

Guilt feelings are connected intimately with oral sensations, or rather with intestinal sensations. The monograph by Nunberg about guilt feelings[24, 26, 28, 29] supplies abundant evidence on this thesis. For example, remorse and compulsion symptoms with the significance of atonement, as well as all attempts to "undo" something in order to satisfy conscience, are regularly unconsciously thought of as a giving back of contents of the body.[25] And this is the case not only if the deed itself has been regarded as an incorporation. It arises, also, from the circumstance that the superego is felt as an introject pressing from within.

The refusal of food by depressed persons generally expresses the idea that this pressure from internalized objects should not be increased by incorporating still other objects.

Guilt feeling not only has an oral character in general but an oral-sadistic character in particular. The term *qualms of conscience* expresses this as well as the German *Gewissensbisse*, both expressions being mere descriptions of the way in which the sensations are actually felt.

However, guilt feelings are not manifested in bowel sensations alone. The genetic relation to anxiety is shown in the fact that a bad conscience may produce the same circulatory and respiratory sensations as anxiety. "My heart is heavy," or "I am not able to breathe freely" are expressions of bad conscience.

In the case of depression, a decisive pathogenic regression increases this sadistic nature of the superego.

The idea has been expressed that anxiety may correspond to the repression of sexuality, whereas guilt feeling may correspond to the repression of aggressive drives.[2, 18] This seems too gross a co-ordination.

The ego, wedged between instinctual demands and guilt feelings, has two possibilities: it may obey the superego and turn against the drives, or it may rebel against the superego. There are as many compromises possible between obedience to and rebellion against the superego as there are compromises between obedience to and rebellion against external authorities. A very frequent type of compromise is temporary ingratiation for the purpose of preparing a later rebellion.

A few words are relevant about the conception of a need for punishment. The pressure from the part of the superego to which the ego is exposed creates first of all a need for getting rid of this pressure, for regaining the lost self-esteem, and for reassurance against possible feelings of annihilation. This aim is best achieved by "forgiveness." After the experience that punishment may be a means of achieving forgiveness, a need for punishment actually may develop. The punishment longed for is a means of achieving forgiveness; the individuals in question certainly would prefer it if they could achieve forgiveness without first undergoing punishment. In "moral masochists," however, the situation may be more complicated: punishment may be asked for not as a means for forgiveness only but also as a kind of distorted substitute for sexual gratification.

Disgust and Shame as Motives for Defense

Less is known about other affective motives of defense, but it seems that their origin and development can likewise be clarified by applying the table of triple stratification.

Disgust as a motive of defense certainly is directed against oral demands,

a fact that connects it with guilt feelings. Actually, certain feelings of disgust are very similar to certain types of guilt feelings, for example, disgust with oneself. The connection with anal eroticism is, of course, also obvious.

Applying the triple stratification table in disgust, we may say:

1. The forerunner of disgust is an archaic physiological defense syndrome which is automatically produced as soon as something repulsive reaches the digestive tract. The first negative judgment of the infant's pre-ego is "This is not edible," which means "I should spit this out."

2. The strengthened ego learns to use this reflex for its purposes and turn it into a defense—first into an expression of negation in general,[15] later into a defense against certain sexual, especially oral and anal, drives. This, again, is a signal: "If you do not give up this demand, you will have to spit and vomit."

In a normal child a part of his anal-erotic interest in feces may be turned directly into a readiness to develop reactions of disgust.[9] Overly intense disgust reactions betray their character as a reaction formation by an occasional breaking through of the original coprophilia in dreams or in symptomatic acts. The disgust of hysterics as a response to sexual temptation may be looked upon as an extreme denial of unconscious receptive sexual strivings: "I not only do not want to take anything into my body; I even want to spit or vomit something out of my body."

3. There are neurotic "attacks of disgust," corresponding to "panic" in anxiety, in which the ego, because of previous blockings, is completely overwhelmed by the affect which was intended for defense purposes.[6]

Shame as a motive for defense is mainly directed against exhibitionism and scoptophilia. It is not simply a specialized form of castration anxiety (fear of the castrating "evil eye"), but a more specific feeling, in the last analysis undoubtedly also rooted in a primitive physiological reflex pattern,[7, 9, 22, 27] Shame, too, in many respects is connected with guilt feelings—"shame of oneself".[10]

"I feel ashamed" means "I do not want to be seen." Therefore, persons who feel ashamed hide themselves or at least avert their faces. However, they also close their eyes and refuse to look. This is a kind of magical gesture, arising from the magical belief that anyone who does not look cannot be looked at.

It is an interesting fact but one not easy to explain that shame seems to be connected in a specific manner with the phenomena of urethral eroticism. That the specific shame punishment of pillorizing is customarily used against wetting only shows that the same connection between shame and urethral eroticism was already effective in the previous generation. The aim of ambition based on urethral eroticism is to prove that there is no need to be ashamed anymore.

Probably the following phases may again be differentiated: (1) Shame as an archaic physiological reaction pattern. Being looked at is automatically

equated with being despised. (2) The ego uses this physiological pattern for defense purposes; signal: "If you do this or that, you may be looked at and despised." (3) The signal fails to operate in dammed-up persons, so that an overwhelming paniclike shame is experienced.

As in guilt feelings, the ego may turn not only against instinctual impulses in obedience to disgust and shame but may also ward off the affects of disgust and shame themselves.[9, 30]

Summary

In the neurotic conflict (between the ego and the id) an instinctual drive seeks discharge in a struggle against an opposing anxiety (guilt feeling, disgust, shame). The drive tends toward the world; the counterforces tend toward withdrawal from the world. The drive seems to be governed by its hunger for objects; the counterforces seem to be governed by a striving to avoid objects.

Are There any Innate Primary Anti-Instinct Forces?

Do any innate tendencies exist to suppress or inhibit sexual or aggressive impulses, besides externally aroused feelings of anxiety, guilt, shame, and disgust, tendencies that might operate even without frustrating experiences? Perhaps the helplessness of the human infant, which necessarily brings about traumatic states, suffices to create a primary hostility of the ego to the instincts? Perhaps a taboo on incestuous love, which is so drastically expressed in many primitive societies, may be something innate, and a main cause for the forces effective against the Oedipus complex?

Ideas of this kind do not seem to be warranted. There is no evidence that hypotheses of this type are necessary for the purpose of explaining the facts of the neuroses. The effects of infantile helplessness would ordinarily be overcome when the child is no longer helpless; if they persist, it is due to experiences that convinced the child of the dangerous nature of his impulses. Whenever we analyze neurotics, whose incest taboo has made them repress their Oedipus complex, we find that experiences are responsible for the anxieties and guilt feelings, and that they are the motivating forces for their repression.

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PRACTICAL APPROACH TO THE WAR NEUROSES

By CAPTAIN RALPH R. GREENSON, M.C.*†

The psychiatric war casualty is the gravest challenge military and civilian psychiatrists have as yet faced. These patients not only represent a medical problem, but they forecast the possibility of serious social and political repercussions. For this reason definitive psychiatric treatment can no longer be considered a luxury for the few, but becomes a must for the many. This paper is not an attempt to supplant the orthodox classification of the neuroses. It is, however, an attempt to organize the great mass of clinical material of the war neuroses into syndromes and reaction patterns which afford clearer and quicker insight into specific psychodynamic constellations. This is particularly imperative in the military situation where brief psychotherapy is the only type of treatment practicable and where most of the personnel are psychiatrically untrained. For these reasons, it became necessary to organize the phenomena of war neuroses into usable, practical categories.

Grinker and Spiegel in their monograph *War Neuroses in North Africa* made the first significant American contribution of clinical material on war neuroses in World War II. At that time, however, they did not attempt a dynamic classification.

After studying thousands of cases, three distinct categories were arrived at. These categories were not mutually exclusive; patients often showed characteristics of many groups. In each category the intensity of the symptoms ranged from severe to mild. The advantage of this grouping lies in the fact that a brief interview usually suffices in affording recognition of the specific pattern and the pattern readily gives a clue to the deeper psychodynamic factors and best therapeutic approaches.

The data on which this paper is based were observed and studied at the Army Air Forces Convalescent Hospital, Fort Logan, Colorado. The vast majority of cases were Air Corps personnel, combat returnees. Of these, the greatest number were enlisted men; in order of frequency: aerial gunners, ground crew personnel and finally officers on flying status.

* Chief of Operational Fatigue Section under Lt. Colonel John M. Murray, Director of Aviation Psychiatric Training Department, AAF Convalescent Hospital, Fort Logan, Colorado.

† Major Oscar E. Hubbard, former Chief of Neuropsychiatry; Major Pasquale Piccolo, Flight Surgeon; and Captain Henry Lihn, Flight Surgeon, all generously contributed the results of their clinical experiences and observations in helping with the preparation of this paper.

This discussion will limit itself to what may be called the true war neuroses in the soldier whose social and psychiatric case studies showed a healthy background. Nevertheless, the abnormal stresses of war can break down even the strongest personalities so that it is possible to see severe types of war neuroses in individuals who were formerly psychologically robust. (It is also striking that many seriously neurotic and even psychotic individuals return from severe combat stress relatively unscathed.)

Group I: Danger-Anxiety Type

Presenting picture: These patients shake, sweat, are restless and jumpy. In addition, they complain of insomnia, battle dreams, startle reaction, and excitability. Generally, they are not conscious of being afraid. In some cases the symptoms begin suddenly after a particularly hazardous mission, after bailing out, crash landing, or fire. In others the symptoms start gradually, increasing with each succeeding mission completed. Finally, there are those who develop their symptoms only after their return to the Zone of the Interior, when they can afford to let their defenses down. In the severe cases the patient will usually avoid everything which might remind him of his combat experiences. In the less severe cases there is much talk of rough missions and flak, but this talk is always conducted with a forced air of bravado very reminiscent of adolescents boasting of the tough games on the athletic field. The mildest cases talk freely of their hazardous experiences, trying to outdo one another as to how terrible their missions were and how frightened they felt. Here one sees either relatively healthy individuals in a phase of catharsis or a kind of counterphobic attitude. They can talk about it comfortably just as long as it is only talk. The talking itself is a self-administered reassurance according to the formula: See, I am not afraid, I can talk about it. The really traumatic factors, namely, panic, killing and bloodshed are never mentioned and for these aspects of the problem these patients develop a phobic avoidance. The sound of an airplane is often enough to precipitate a marked exacerbation of all the symptoms.

This is the most prevalent picture seen at this hospital, and is generally present to some degree in all forms of war neuroses. It is most commonly found in men who flew combat missions where there was intense flak and fighter opposition.

Psychodynamics: We are dealing here with a combination of traumatic neurosis and anxiety state. These men have broken down primarily because they were exposed to excessive amounts of danger; either less danger over a prolonged period of time or very intense danger over a short period of time. The more recent the combat experiences and the more frequent the panic situations experienced, the more one is apt to find trau-

matic neuroses. Here the painful situation which overwhelmed the ego is constantly repeated in fantasy, thought and dream, as an attempt of the ego to master belatedly the overwhelming influx of stimuli it had failed to handle in the traumatic moment. When the danger was less intense and more prolonged one is more apt to find the development of anxiety equivalents. The affect of fear and the fear-producing situations are repressed, or in the process of being repressed, and instead appear the many varied signs and symptoms of fear. These men are not aware that they are still suffering from the effects of their combat experiences. On the other hand they maintain a phobic avoidance of all situations which would remind them of their original fear. Of particular importance in addition to tremor and sweating, are the gastro-intestinal disturbances. Here one frequently finds all the typical symptoms of gastric distress as the consequence of pent-up emotional tensions, i.e. anorexia, nausea, and vomiting. These symptoms are not conversion hysteria manifestations, in that there is no repressed specific ideational content and they disappear with the diminution of the dammed-up emotional state.

Therapy: The traumatic neurotic patients react to intravenous sodium pentothal by re-living and acting out the traumatic experiences in the most explosive fashion. Patients in an anxiety state usually recount their experiences, but with a great deal of abreaction. These patients must be prepared for narcosynthesis and must be reassured as to the beneficial effect of this cathartic procedure. The material obtained in the pentothal interview must be worked through with the patient, particularly those portions which were hitherto repressed. The patient must be given insight into the dynamics of his situation, but great care must be taken in the dosages of insight and traumatic material one makes conscious. The patient must be made to face that quantity of fear which he can now tolerate without having to repress it once more or without developing a panic reaction. Constant reassurance is an important therapeutic technique. The patient must be urged to face those past dangerous situations now that he is actually safe. He must be convinced that the first step in forgetting painful events is to remember them.

*Prognosis:** In general, this group of cases offers the best prognosis. Very often it is necessary to remove these cases to civilian life since they are still susceptible to those stimuli so frequent in the military situation which might reactivate the traumatic event. It might be said that the sooner after combat treatment is instituted, the better the results.

Case 1: This patient is a 23 year old gunner on a B-26 who developed the symptoms of his traumatic neurosis after a particularly hazardous mission in which he was

* All statements on prognosis refer to our experiences at Fort Logan Convalescent Hospital.

trapped in a burning plane. He managed to finish out his tour of duty, but shortly after his return to the States began to suffer from battle dreams, restlessness, tremor and sweating. This patient refused to talk of his combat experiences.

The following is an extract from his pentothal interview. He was given 16 cc. of a 2½% solution, fell asleep and awoke suddenly screaming, "Fire—fire—fire broke out—fire—fire—there's a fire in the bomb bay—fire—fire—get me out of here. Come back, you rats, I helped you—come back—I'll blow up—my parachute—my parachute is stuck—they all ran away—I'm alone—I'm in a jam—my chute is stuck—it's stuck. Fire—fire—fire—I hate fires—get me out. I'll blow up—please get me—please get me out—gotta get out—gotta get out—please help me—please—please—please. There's a fire in the bomb bay—there's a fire in the bomb bay—I'll get out—I'll get out—I'll get out. I'll blow up with the ship—I'll blow up—I'll blow up—there won't be a piece left—not one little piece—not one piece—please—my chute is stuck—stuck—stuck."

The patient screamed, writhed, cried, begged and tried to stick his head under the railing of the bed in an obvious repetition of his situation when his plane caught fire after that crash landing and he was left alone, caught in the navigator's hatch. After three sodium pentothal interviews the patient was able to verbalize this traumatic episode. His tremor and sweating diminished and he was able to sleep without combat dreams. He returned to limited duty after seven weeks of hospitalization.

Case 2: This patient is a 22 year old waist gunner on a B-17 who developed primarily the symptoms of an anxiety state toward the end of his full tour of 35 missions in the European Theater. This soldier was admitted to the hospital two months after his return from combat, complaining of tremor, sweating, restlessness, loss of appetite, insomnia, and startle reaction. He spoke reluctantly of his combat experiences; never in detail and with little emotion.

The following is an excerpt from his first sodium pentothal interview. He was given 10 cc. of 2½% solution, fell asleep smiling and awoke suddenly shouting, "Flak—flak—flak—flak—fighters—fighters. I was scared—awful scared—I would have bailed out only for my pilot. Flak—that god damned flak—as big as a globe busting in front of your face like a globe. We shouldn't have gone through it—we should have gone back, but you got to keep going—you got to keep going. We went to Toulon and there were two engines shot out and we lagged behind and I was scared, awful scared. Oh, God, I can't stand it, but God was good to me—I was lucky—God was with me. Those rockets exploding off the wing. I was scared, Doc—I was yellow, Doc—I was awful scared—that flak—all you do is sit and wait—there's nothing to do, Doc—you just sit and wait. I couldn't stand it—I couldn't stand it. I would have bailed out if not for my pilot. These enemy Me 109's kept coming in—kept coming—coming. Jesus Christ, they don't give a damn—they just keep coming".

This patient received two sodium pentothal injections and was given insight into how he was trying to repress his fear reactions. Gradually most of his symptoms left except for tremor and sweating which persisted, but to a lesser degree. He was returned to civilian life after 8½ weeks of hospitalization, and a letter was received from him one month later which stated that he was successfully carrying on with his pre-war job.

Group II: Passive-Dependent Types

a. Deprivation-passive type

Presenting picture: These patients are characterized by apathy, submissiveness, resignation, lack of interest and passivity. There is very

little depression, very little anxiety and practically no belligerence. They spend most of their time lying on their beds staring at the wall and it is very difficult to get them to participate in any kind of program. They frequently complain of fatigue, despite the fact that they sleep many hours and spend most of the time physically at rest. They complain quietly, listen to the stories of the other men in silence, make no demands, and ask no favors.

Our observations here indicate that these patients have spent a long period of time in the Southwest Pacific, China-India-Burma, Aleutians, and North Africa, were evadees who spent months hiding in enemy-occupied territory, or were prisoners of war. It has been found that these cases are more frequent in the Ground Forces than in Air Corps personnel; among Air Corps personnel it is more prevalent in non-flying personnel than in flying personnel. Men from the Southwest Pacific and Aleutians develop these symptoms about eighteen months after going overseas. Prisoners of War reach this state after six months of captivity.

Psychodynamics: These men have broken down because they were unable to tolerate prolonged periods of deprivation; i.e. loss of love in all its many equivalents. These men from the above-mentioned theaters have spent long periods of time in situations far away from their loved ones, where the food was bad, the climate was miserable, where there was no affection, no tenderness, much drudgery and much boredom. It is obvious that the men who have remained away from home the longest, the men with the least rewarding jobs and the men stationed on the smallest islands will be the ones to break down in this way. They will complain that they have to go home to their mother; they are needed; the home, the family will go to pieces without them. Analysis quickly reveals that here they are unconsciously projecting their own needs onto the family. It is the patient who will go to pieces if he is not at home; he needs his mother—he has to be loved again like a little child. Intuitively he recognizes this will cure his hurt. These men have regressed to an oral-dependent, passive, longing phase of development. They have starved so long, they have rebelled fruitlessly against constant frustration for so long that they now have withdrawn to this primitive, infantile reaction of the downtrodden, abandoned child. They wait for supplies of love, but they wait hopelessly. Fenichel* suggests that, in a sense, this too is a traumatic neurosis. The deprivation has now overwhelmed the Ego and it no longer perceives the demands of the Id or the possibilities for satisfaction in the external world. The Ego is unconsciously influenced by the repetition of the past frustrations and defeats.

* Personal communication.

It is important to remember that these cases do not begin with this passive reaction to deprivation. At first this reaction to frustration was aggression—attempts to break down the restraining forces. In this early phase belligerence and hostility are characteristic of their behavior. This phase may then be followed by a depressive reaction when their aggression is turned against their own Ego. Only when the deprivation reaches traumatic, overwhelming proportions do we find the utterly resigned, apathetic attitude.

Therapy: The decisive factor in the treatment of these men is to give them what they need; namely, the feeling that they are loved, that they are needed, that they are important. Obviously we are ill-equipped in the Army to provide this for the men. Home, wife, mother, sweetheart; that is the best therapy for severe cases. With sodium pentothal intravenously there is a temporary improvement, due largely to its cathartic effect, but they quickly relapse. In the less severe cases the sympathetic and warm attitude of the psychiatrist and the hospital staff may often be of decisive value. As they improve, hostility and hatred come to the surface. In general it may be considered a good prognostic sign when they become aware of and give vent to their pent-up resentful feelings.

Prognosis: From the military standpoint these cases have the poorest prognosis of all. Returning them to their home is often the only adequate therapy for the severe cases. The milder cases, however, often respond magnificently to kindly treatment, plus psychotherapy. Another particularly important prognostic indication is the history of a happy home life. The memory of childhood satisfactions and security is a valuable index of recovery potentialities. The severest cases almost invariably have a history of being products of broken homes, orphan asylums, etc.

Case 3: This soldier was a 26 year old crew chief stationed in North Africa for two years. He was very quiet, withdrawn and seclusive—the typical picture of a deprivation—passive dependent type of reaction. There was a trace of depression in this man, but most striking was the hurt look in his eyes and his resigned manner of behavior. It was obvious that he expected nothing. During the interview he spoke quietly and monotonously.

"The dust, the sand, the dirt, the bugs and the loneliness. The food was terrible. Our only meat was goat stew—goat stew for breakfast and goat stew for dinner. Dust and goat stew. You know, Doc, there was even goat stew Christmas morning and Christmas dinner. Twice a day, goat stew. The only civilians nearby were Arabs—there were no white women and there was nothing to do in your free time except sleep. It was hot and you worked and you sweated and you ate—goat stew—and you slept—that's all there was, day after day for 22 months. You were always dirty and always thirsty. You stopped being hungry. You worked in the sun and the dust and there was nothing to do afterwards but sleep. Dirt and bugs and goat stew and nothing to do. Twenty two months of it—every day for twenty-two months."

Tears would come to the patient's eyes as he spoke, but they never overwhelmed him. Under pentothal he repeated the same stories, only now he cried piteously. When he was finally told he was going to be returned to civilian life, he responded to this by crying. He got up and slowly left the room and there was no noticeable change in his behavior. For several days he didn't believe it, and only just before he left did he manage a faint smile and say, "Thanks."

b. Helplessness—pseudo-belligerent type

Presenting picture: These patients behave like adolescents. They are younger, chronologically, than most of the patients. They present a very obvious mixture of aggressive, cocky and immature, insecure reactions. There is much loud talk and bragging in front of the "gang." This persists only for a short time in the psychiatric interview only to be replaced by tears, the admission of great loneliness and longings for home and mother. It is striking that these men talk so much of aggression of all sorts, but rarely ever do anything. This is in contradistinction to other belligerent types.

Psychodynamics: The characteristic finding in the history of these cases is a terrifying situation in which the patient felt helpless. It was the awareness of this helplessness which was the traumatic element, not the danger. The patient responded to the helpless feeling by passive longings to be protected, to be loved, to be cared for. He prayed to God or he called for his mother. Later he attempted to deny this state of affairs to himself and his comrades and assumed a belligerent attitude. However, the veneer is thin and their passive-dependent needs betray themselves very readily. The similarity of this picture to typical findings in adolescents is very striking. Here, too, the Ego is none too secure in its recently won independence and regresses quickly to a more dependent level only to build a reaction formation of toughness as a disguise.

Therapy: These patients respond well to sodium pentothal. It is very important, however, once the helplessness, loneliness, and longings for the mother come to the surface that the patient's shame for these feelings be counteracted. He must be reminded that actually he is only very young at being a man and even older men sometimes need a mother. The doctor must play a warm, kindly, paternalistic role. The belligerence is handled by pointing out that it deceives no one and a really secure man doesn't need this pretense.

Prognosis: Much better than the deprivation-passive type. Even severe cases of this type do recover.

Case 4: This soldier was a 20 year old right waist gunner on a B-17 in the ETO completing thirty-five missions. He was loud and aggressive; made fun of the men who participated in the rehabilitation program, but whenever he was called into my office was visibly shaken and tearful. An extract from a sodium pentothal inter-

view: "I was the roughest and toughest guy in the outfit. I was a big time operator. Yeh, until that damned Regensburg raid. Flak, flak, flak, and those fighters. Rough, rough, rough. I never saw the night time turn into day time before. Flak, fighters, flak, flak, flak. I'd pray and I'd cry. Me, the big shot, crying. Look around and pray and cry. Flak all around; it was drivin' me crazy. Captain, I'm goin' to cry. Look at me crying—like a god-damned baby. I gotta go home, Captain. I'm no good to this Army. I either blow my top or I cry. What's the matter with me, Captain? I was never this way before. Oh, Mamma, Mamma. Oh, Captain, I gotta go home."

Group III. Guilt Laden Types

Here we find a considerable number of cases which have in the foreground of their clinical picture severe guilt feelings, conscious or unconscious, with strong feelings of self-reproach and an unconscious need for punishment. It is possible to distinguish three different types of reaction to these guilt feelings: (a) Guilt-Belligerent Type, (b) Guilt-Anxiety Type and (c) Guilt-Depression Type. All these cases have in common a feeling of guilt in regard to their aggressive impulses which were released in combat and which now they strive to re-repress. They all feel guilty for having left their comrades overseas. As a result the Superego in these patients is overly strict. Furthermore, all these cases tend to act out their aggressions more than the other types. Simmel explains this by pointing out that the Army situation itself represents a regression to a level where the Superego, i.e. authority, is externalized. Tension between Superego and Ego would tend to be expressed in acts against the external world. These patients frequently manifest gastro-intestinal symptoms, but here they usually represent a specific emotion expressing: I am fed up or I can't stomach this any longer.

a. Guilt-belligerent type

Presenting picture: These patients are conscious of their guilt feelings and have not repressed the situation in which the guilt was incurred. The guilt-provoking situation is a real one and a certain amount of self-reproach is deserved. Clinically characteristic for these men is belligerence, agitation, open hostility, aggressive acts, temper outbursts and a great readiness to hatred of their officers and the Army in general. Despite the fact that these patients are conscious of their guilt, they are reluctant to disclose this information and have no awareness of the connection between the guilt and the belligerent behavior. They drink a great deal, are frequently in trouble with the military police and are constantly breaking rules and regulations. They are the ring leaders in all group escapades, the loudest talkers and the most popular of patients. They will talk of their great secret only while under the influence of alcohol or sodium pentothal. Sometimes they may

speak of the event, but then without affect and with the omission of significant details.

Psychodynamics: These patients suffer from a severe and sadistic Superego which is constantly punishing the Ego. Only part of this is due to the guilt feelings incurred in the traumatic situation. The sadistic Superego is reinforced in its behavior by the sadistic impulses from the Id which now, by the patient's return to the Zone of Interior, is deprived of its former outlets in combat. The Ego which in combat did permit access to sadistic impulses from the Id now regresses in its attmept to curb the destructive impulses and tries to internalize the conflict. As a result guilt feelings are increased, the attempt at internalization fails, and these patients now behave toward the outside world as their Superego behaves toward their Ego. Part of this is an attempt to provoke the external world to punish them so that they may pay for their guilt.

Therapy: These patients respond only fairly well to sodium pentothal and do not gain any definite benefits, except for the fact that it permits the recital of their secret. They do respond however to individual psychotherapy, but this must be of a specific kind. First of all, the patient must feel that the therapist is sympathetic. However, it is impossible to really communicate with these patients unless the psychotherapist talks and acts like their Superego. To a certain extent the psychiatrist must imitate the harsh, critical attitude of the Superego and by this imitation he establishes contact with the patient. This makes the patient aware of the overstrictness of his Superego—then he can substitute the more tolerant Superego of the psychiatrist which must be manifest to the patient despite the use of this technique.

Strong, forceful language is necessary. One must be, in a sense, hostile as the patient is hostile, but never hostile to the patient. The technique is not easy and has its dangers. Nevertheless, it is worthwhile because it is effective very quickly. Once the patient is aware of what he is doing to himself and why, a realistic approach to the problem of self-punishment can be made. Reassurance and cheerfulness is of no value to these patients. One can only strengthen the Ego by pointing out past accomplishments, etc., but again this must be done in a way which anticipates the patient's self-deprecatory, belittling attitude.

Prognosis: The prognosis must be guarded and depends on the seriousness of the guilt-provoking situation. Once positive transference is attained, the hostility is replaced by guilt feelings and it is possible to achieve clinical recovery by then giving the patient insight.

Case 5: The following is a condensed version reflecting the behavior of the patient and the therapeutic technique to be used in the Guilt-Belligerent type. This patient is a 23 year old gunner on a B-24 who completed a tour of duty in the Mediterranean

Theater of Operations and was sent to the convalescent hospital because his flight surgeon suspected this man was not able to render further useful duty.

The patient entered the ward in a very belligerent, hostile frame of mind, stating flatly, "I feel OK. There's nothing wrong with me. I want to get to hell out of this place. I hate hospitals. I'm not sick. I want to get the hell out of here, and fast." All attempts to show the patient that we were trying to help him and that we wanted him to go back to duty, but that obviously he was not well enough to go to duty, seemed to make no impression on him.

In the second interview the psychiatrist said, "Joe, I know something is wrong. You are mad at the whole world and you are just waiting for a chance to blow your top. But you are also mad at yourself, Joe. I know you won't talk. That's OK with me, I'll wait. I know you don't like me and you hate like hell being stuck here, but I am going to try to make you feel better even if you don't give a damn."

To this Joe responded, "I got something I won't talk about, Doc, I don't want no 'flak juice'. I just won't talk about it. It ain't pretty and I won't ever forget it."

The doctor now answered, "That's OK with me, Joe, go on torturing yourself, get yourself in trouble, get in the guard house. You hate yourself and you are going to take it out on yourself—O.K. But when are you going to stop—when will you have had enough? Do you want to chop off your right arm—will that be enough punishment?"

Joe: "You see, Doc, there's something I won't forget and it ain't pretty. I was trapped in a burning plane and only the navigator and me were alive. I had a heck of a job getting out and the plane was burning and it was going to explode. But I got out and the navigator called me. He said, 'Joe, Joe, help me, I'm stuck in here: But I was scared, Doc—I was yellow—I knew the plane would explode. It did explode, Doc, and they never found anything of that navigator. That ain't pretty, Doc, and I ain't going to forget it, Doc."

"No, that ain't pretty, Joe, and you won't forget it for some time, but getting yourself in trouble and hating yourself and torturing yourself and picking on yourself and being cruel to yourself and blowing your top isn't going to help you forget it, Joe. What price do you want to pay? Yes, you have to pay a price, but how much? I suppose you wish you had been killed in that explosion, then everything would have been all right. Yes, you were scared, you are a human being, but that's O.K., Joe wasn't supposed to be scared, Joe was supposed to be a dope who doesn't know danger when he sees it. What price do you want to pay, Joe? Get busted to a Private? Get in the Guard house? Is that what you want?"

Joe: "I'm no good, Doc,—I'm just no good, Doc."

"I know you are just nothing at all—you never did anything. The 50 missions you did—we'll forget all about that—that's nothing. And you worked hard before you got in the Army and you supported your mother, but that's also nothing. Everything is nothing. You got scared and you ran away from a burning plane and that was terrible and now we will forget everything that Joe ever did that was good and decent. O.K., Joe, if that's what you want—go on punishing yourself, tormenting yourself, cut off your right arm. It just doesn't make sense to me, Joe. You have got to make up for what you did, but there's a smart way of doing it—not the way you are doing it now."

This is a good example of how one must imitate the harsh superego of the patient without making the patient feel you are hostile toward him. Joe responded well, but slowly. After about four interviews he was playing the guitar in the ward and toward the end of his stay he said he wanted to go back to duty and he wanted to go back overseas. He was determined to make up for what he had done.

b. Guilt-anxiety type

In these cases the guilt feelings are unconscious and the guilt-provoking situation is repressed.

Presenting picture: The same as the Danger-Anxiety Type.

Psychodynamics: The danger in these cases is from the punishing Superego instead of external danger. Once the guilt is made conscious there may be a transition to the Guilt-Belligerent type of reaction. From a theoretical standpoint it is conceivable that before a guilt-provoking situation has been repressed there is a phase of belligerent behavior. This has as yet not been confirmed clinically.

Therapy: Intravenous sodium pentothal to gain the repressed material; then working through slowly plus reassurance as described for the Danger-Anxiety Type. If the anxiety should change to a hostility reaction, then one should utilize the technique as described for the Guilt-Belligerent type.

Prognosis: These cases give some of the most favorable results.

Case 6: This patient was a 22 year old engineer-gunner on a B-24 in the Mediterranean Theater. He came into the psychiatric ward two months after his return from combat with the classical symptoms of the Danger-Anxiety type of reaction. Under sodium pentothal he repeated many hazardous missions, but did not improve until a situation came to light which had been hitherto repressed. On a very dangerous mission in which their plane had two engines shot up and was riddled with flak, the ball turret gunner came up from his ball turret and refused to go back. The patient, who was the engineer and in charge, forced the gunner to go back and the gunner was killed. The patient felt very guilty, felt he was to blame for the death of this gunner, but completely repressed this incident, which only came to light under the pentothal.

Once this guilt-provoking situation was worked through with the patient he lost his anxiety symptoms and went through a brief episode of belligerence in which he fractured his right wrist in a brawl. Further insight into the dynamics of this new development brought about a marked quieting of the patient's hostility and gradually all his symptoms disappeared, except for a mild tremor and restlessness.

c. Guilt-depression type

These are cases in which the guilt feelings are repressed or at least certain aspects are repressed and the depression and guilt are related to the loss of a "buddy".

Presenting picture: Clinically these patients are characterized by restlessness, tremor, sweating, hostility and depression. In other words they manifest some of the symptoms of the Guilt-Belligerent and Guilt-Anxiety Type only less pronounced, plus the element of depression. They talk, brood and dream of their dead "buddies" and usually in three ways: "My buddy was a better man than I; why did he die and why was I spared? I want to go back overseas and get killed and join my "buddies". I want to get revenge and kill all the Germans and here I am, in a hospital."

Psychodynamics: The psychodynamic factors here are very complex since there are many different components. What is new here is as follows:

Part of the picture is the picture of mourning and grief, i.e., the loss of the loved object, the painful saying goodbye again and again in all situations which are reminiscent, and the feeling of loss of part of the self. This is the normal part; what is pathological is the guilt. It is the guilt which prevents full mourning and grief and produces instead a chronic depression. This may be based on a real situation in which the patient is to blame for the loss of his friend. Then you have the constellations as described above in III a and b. However, the decisive factor here is the guilt which is based on ambivalence, i.e., repressed hatred for the buddy. "I loved him like a brother," brings with it the unconscious confession, "I hated him like a brother."

It is this repressed hatred for the cherished and now lost friend which acts as the spark which sets off the wrath of the Superego against the Ego in the form of self-reproach, loss of self-esteem, and need for punishment. It is important to remember that ancient ambivalences felt toward real brothers are re-mobilized in this situation.

Another factor in the origin of the ambivalence is stressed by Fenichel* and Grinker.[4] All combat soldiers know that a certain percentage of them will be killed and all hope that they will be spared. This situation thus brings forth the wish: rather you than me. Even where men are particularly close friends, the drive for self-preservation wins out in the formula: if one of us is to die, then I hope it is not me. It is this wish for survival, which is perceived as a death wish against their comrades, that produces the guilt feeling when the buddy is lost. Thus all combat soldiers are particularly vulnerable to this type of pathological mourning.

Therapy: All the techniques as described above are needed to work out these cases, depending on what is in the foreground. Generally, the guilt feelings have to be worked out first. Once this is accomplished then the normal grief and mourning for the lost buddy can take place and eventually come to an end. Sodium pentothal is of definite value in releasing the repressed ambivalence and in allowing the pent-up sorrow to come to the surface. Particular care must be taken in dosages of insight given. In approaching the theme of hatred one begins by using words like resentment, anger, etc. It is often inadvisable to probe into the ancient ambivalence and one can achieve good results by working out the recent situation alone. The feeling that one is unworthy of having been saved and the wish to be killed has to be overcome by analyzing the guilt. The wish for revenge, once it has been shorn of its neurotic component, can be used in getting the patient back to duty.

Prognosis: Not as favorable as Guilt-Anxiety type, but better than the Guilt-Belligerent type.

* Personal communication.

Case 7: This 21 year old soldier was a top turret gunner in a B-17 and completed a full tour of duty in the European Theater. He was admitted to the psychiatric ward some three months after his return to the Zone of Interior complaining of depression, restlessness, agitation, and disturbing dreams. He spoke very little of combat, mentioned briefly the loss of his good buddies, but refused to elaborate on this theme. He

WAR NEUROSES

TYPE	CLINICAL PICTURE	THERAPY	PROGNOSIS
I. Danger-Anxiety	Tremor, sweating, restlessness, jumpiness; insomnia, battle dreams, startle reaction, excitability	Reliving under sodium pentothal, with working through of recovered repressed memories	Very good. Probably best of all, especially if early treatment is given
II. Passive-dependent		Mild cases—Sympathy and affection from all personnel plus psychotherapy	Poor—from military standpoint. Fair on discharge
a. Deprivation-Passive	Apathy, submissiveness, resignation, lack of interest, inactivity, fatigue	Severe cases—Discharge to return to loved ones	
b. Helplessness—pseudo-belligerent	Aggressiveness, cockiness, immaturity, insecurity. Loud talking and bragging to companions, crying and admission of loneliness and longings to psychiatrist	Sodium pentothal, releasing feelings of helplessness and longing plus reassurance and interpretation of bluff defense against these suppressed feelings	Quite good
III. Guilt Laden			
a. Guilt-Belligerent	*Conscious* guilt feelings, belligerence, agitation, temper outbursts, hatred of superiors and Army in general. Justifiable self-reproach elicited	Sodium pentothal only to obtain recital of guilty secret. Sympathy but hard, tough attitude toward the symptoms, not toward the patient	Guarded. Depends on seriousness of guilt-provoking situation and patient's real culpability
b. Guilt-Anxiety	*Unconscious* guilt feelings. Same clinical picture as Danger-Anxiety type	Sodium pentothal to obtain repressed material, plus slow working through and reassurance. If anxiety changes to belligerence, treat as III a above	Quite good
c. Guilt-Depression	Tremor, sweating, restlessness *plus* hostility, *plus* depression. Guilt precipitated by loss of a buddy	All of above techniques, depending on what attitude is in foreground. Usually deal with guilt feelings first, permitting normal grief and mourning. Sodium pentothal to release ambivalence and suppressed sorrow. Deal with recent ambivalences only. Utilize revenge motive for new duty assignment	Midway between III a and III b

would pace the floor clenching his fists, muttering to himself, but never committing any overt aggressive act.

An extract from his sodium pentothal interview is as follows: "Did you ever see a fella without a head, Doc—did you ever see a fella, a friend of yours, without a head. He was flying on my wing and then I looked at him and there was no head, the blood was streaming all over—all over the fuselage—like someone had spilled a gallon of red paint over it. It was terrible and I had to keep looking. He was my buddy—my best buddy. He wasn't just a friend—I loved him—I ate with him and I slept

with him, and we played cards together and we went out with girls together. He was a nice guy, he never cussed—he was a better guy than me, Doc. A man doesn't look nice with his head blown off—it don't look right. I gave him the last salute, but I knew the salute wouldn't bring him back. He was a nice guy—I wish it was me—I'm no good—those damned Nazi bastards—they killed my buddy—I loved him—he was the best buddy a guy ever had. I got to go back, Doc—I can't stay here—it ain't right—I got to go back and get those Nazi bastards—I want to kill them one by one."

This was a difficult case since there were so many different important factors that had to be worked through. First of all, the patient had to become aware of his own ambivalence toward this friend and the guilt which resulted from this ambivalence. Secondly, he had to face the sorrow of losing a dear friend. Thirdly, he had to get insight into his own sadistic strivings which were re-mobilized by the sight of the blood streaming over the fuselage. Only then could he begin to make new buddies and to find acceptable outlets for his hostility. This patient stayed in the hospital some sixty days before it was felt that he was well enough to return to civilian life.

The above-mentioned clinical pictures are the most prevalent types of reaction we have seen in several thousand psychiatric casualties at Fort Logan. Most of these cases do not appear in a pure form, but one sees combinations; usually anxiety states plus any one of the other groupings. One might speculate as to what one might uncover with prolonged analytic probing of these cases. Undoubtedly, they would be found to fit into the general classification of neuroses. On the other hand, it is interesting to note how many old psychoneurotics do not develop intensification of their old symptoms under the stress of combat, but develop a new clinical picture in addition to their old psychoneurosis. These speculations however, are beyond the scope of this paper. The findings presented above do not contradict the expectations of the psychoanalytically trained psychiatrist when he considers the important traumatic factors in a war situation. This new grouping is by no means to be considered complete or final, but it is intended to serve as a practical aid in brief psychotherapy based on psychodynamic principles.

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BOOK NOTICES

The Management of Neurosyphilis. By Bernhard Dattner. Price $5.50. Pp. 398. New York, Grune and Stratton, 1944.

This book reviews the literature and the author's own vast experiences in an extremely complete, beautifully annotated and easily perused text which has for its arguments that neurosyphilis is the problem of not only the neurologist but also of the general practitioner, the dermatologist, and the internist, and that the changes in the spinal fluid are the most significant diagnostic criteria in all stages of neurosyphilis. Therefore, cyclopedic aspects of the study and evaluation of spinal fluid findings are presented from the point of view of the technical, the clinical, and the metapsychological considerations involved. Comprehensive discussions of all useful methods of treatment of neurosyphilis are presented and closely integrated with remarks about spinal fluid changes occurring in such treatment, so that its immediate effectivity, the immediate and remote prognosis, and the further management of the case may be formulated. An extensive bibliography is included.

There is little question that this book will prove to be of extreme value to those who wish to gain a fuller knowledge of diagnostic, therapeutic, and prognostic factors in neurosyphilis. (Henry Luster)

The Expression of Personality; Experimental Depth Psychology. By Werner Wolff. Price $3.50. Pp. 334. New York, Harper & Bros., 1943.

Werner Wolff's book is unique, being the only volume to establish with what degree of validity personality can be judged from physiognomic features, hand formation, gait, handwriting, narrative style, memory, associations, etc.

Though the book has inadequacies, these are dwarfed by its assets. It is a book that opens a wide, inviting, uncharted field for thinking and investigation and is "must" reading for all professions concerned with human behavior. (David Rapaport)

Greet the Man. By Harold Wilke. Price $1.50. Pp. 218. Philadelphia, The Christian Education Press, 1945.

The author of this book is a minister who has worked in hospitals with wounded soldiers. He was born without arms but has learned to get along successfully without assistance—in eating, writing, dressing himself and so on. He has done considerable graduate work in psychology and medical social work. He discusses the way in which he is able to communicate his own philosophy of cheerfulness to crippled soldiers and others, emphasizing for those who would do similar work that the most important principle for them and for the patient is that the total personality is infinitely more important than the wound or defect—greet the man, he says, and not his disability. (K. A. M.)

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